

THE PSYCHOLOGICAL IMPACT OF PIRACY ON SEAFARERS



“ Almost all seafarers who have been held hostage, and many who suffer attacks at sea, experience some after-effects of the trauma.

(Sparrow, 2011) ”

MICHAEL STUART GARFINKLE, PHD Center for Seafarers' Rights at the Seamen's Church Institute | Department of Psychiatry, Mount Sinai School of Medicine | New York Psychoanalytic Society & Institute

CRAIG L. KATZ, MD Department of Psychiatry, Mount Sinai School of Medicine | Disaster Psychiatry Outreach at Mount Sinai

JANAKA SARATCHANDRA, MD Department of Psychiatry, University of Arizona in Tucson

INTRODUCTION

In 2007, the Seamen's Church Institute of New York and New Jersey (**SCI**), responding to the increasing number of piracy incidents off the coast of Somalia, implored the maritime industry to consider the psychological impact of piracy on seafarers. While some shipowners implemented psychologically-informed policies to care for crews, the industry as a whole lacked an organized, macro-level approach to address mental health. Seeking to help, SCI initiated a clinical study of the effects of piracy on seafarers in 2009.

Several factors complicated the study of the psychological impact of piracy on seafarers:

- 1.** Very little scientific literature exists on seafarers' lives and work. Examples of existing studies include a report on a capsized car ferry that killed 183 passengers (Dooley & Gunn, 1995) and two general surveys of stress among seafarers (Elo, 1985) (Agterberg & Passchier, 1998).
- 2.** Because of the absence of literature, no reasonable baseline exists for normal stress among seafarers.
- 3.** Seafarers' self-reliant culture tends to stigmatize—rather than sympathize with—mental illness, making it less likely that affected individuals would disclose feeling mentally unwell (Lauber & Rössler, 2007).
- 4.** Economic forces make disclosures of psychological symptoms—with corollary concerns about fitness for duty—potential threats to reemployment.

Because of these factors, SCI's systematic study of the psychological effects of piracy on seafarers collected stories of seafarers from the "normal" group—those not directly affected nor displaying symptoms—to construct an impression of what constitutes the average and expectable in seafaring and what represents a deviation from normal.

DESCRIPTION OF STUDY

In the autumn of 2009, SCI designed a study approved by the Institutional Review Board of the **Mount Sinai School of Medicine** for human subjects research.¹ The study employed a semi-structured interview comprising an outline of major content areas for discussion, including a seafarer's personal history, along with employment history, spiritual and cultural beliefs, and finally (if not discussed at an earlier stage of the interview) piracy. Clinical researchers selected this method hoping to generate the greatest amount of spontaneous information and to gather as much context as possible of the seafarer's personal circumstances. SCI identified participants mostly through contact with seafarers at SCI's base of operations in Port Newark, NJ, USA, where the primary investigator, **Dr. Michael Garfinkle**, or his assistant, **Dr. Janaka Saratchandra**, boarded vessels and conducted interviews aboard ships. Clinical researchers made every effort to guarantee the anonymity of participants and protect privacy—both by conducting interviews in a secluded space and by anonymizing the data following the interview.

Over the course of the data collection period, some seafarers who had heard of the study asked to be interviewed, and the ethics approval was amended to include interviews over email and Skype. The data reveal a difference between the sample of convenience and those who solicited contact. The latter group had many more reports of direct contact, including captivity, with pirates (13/21 by phone versus 12/133 in person). This latter group likely felt a need to talk about their experiences, and in all cases, interviewees reported feeling helped in speaking to a professional listener in a private setting.

Of **154** seafarers interviewed ...



- **21** interviewed via the telephone, Skype, or the Internet and
- **133** in person at Port Newark.

AGE of the participants ranged from **18 → 63** and their **EXPERIENCE AT SEA** extended between **1 → 38** years.

11 REPORTED CAPTIVITY (ranging one week to over a year), **14 WITNESSED ATTEMPTED BOARDINGS.**

Clinical researchers interviewed **150 MEN** and **4 WOMEN.**

Ninety-nine seafarers interviewed called the Philippines their home, 15 hailed from elsewhere in Southeast Asia, 17 from Eastern Europe, six from Northern Europe, six from the United States, four from North Africa and seven from South America.

Clinical researchers analyzed all interview data using a strategy of **phenomenological analysis** following Hycner (1985). This approach maximizes openness of communication and attempts to preserve both the richness of individual description and general themes. This paper emphasizes general themes of the interviews reported from an analysis of the frequency of certain themes across all interviews, examining how they emerged in a context. Prior to evaluation, interviewers discussed major themes to reduce the impact of presupposition, and in later interviews introduced some early hypotheses to interviewees at the conclusion of interviews as a “validity check” (Hycner; p. 291). Where quantitative data presented itself, clinical researchers also conducted simple **correlational analysis.**

¹ IRB#09-2111

SUMMARY OF MAJOR FINDINGS

Several general impressions about the sample emerged from analyzing the content of each interview for frequency and intensity.

FROM 2009 TO 2011, OVERT CONCERN ABOUT PIRACY INCREASED ALONG WITH ANTICIPATORY STRESS ABOUT TRANSITING ZONES OF PIRACY, INCLUDING THE INDIAN OCEAN.

Whereas initially interviewers had to prompt most seafarers to speak about piracy, by late 2010 the topic came up spontaneously in almost all interviews within the first third of the dialogue.

The frequency with which seafarers expressed the appeal for **armed guards** aboard ships for protection increased over time. While a minority of those interviewed expressed a wish to arm themselves, most interviewees articulated the probable advantages of appointing well-trained armed guards to ships. Of the officers interviewed, several expressed concern with the current, unencrypted communication methods between vessels and naval support forces, where reporting pirate sightings puts vessels at risk when broadcasting coordinates.

Most seafarers did not endorse the notion that their job is unduly stressful under normal conditions, citing relatively good living conditions aboard most vessels. When prompted to say what would improve daily life aboard ship, many seafarers suggested Internet or telephone access that would allow them to stay better in touch with relatives at home.

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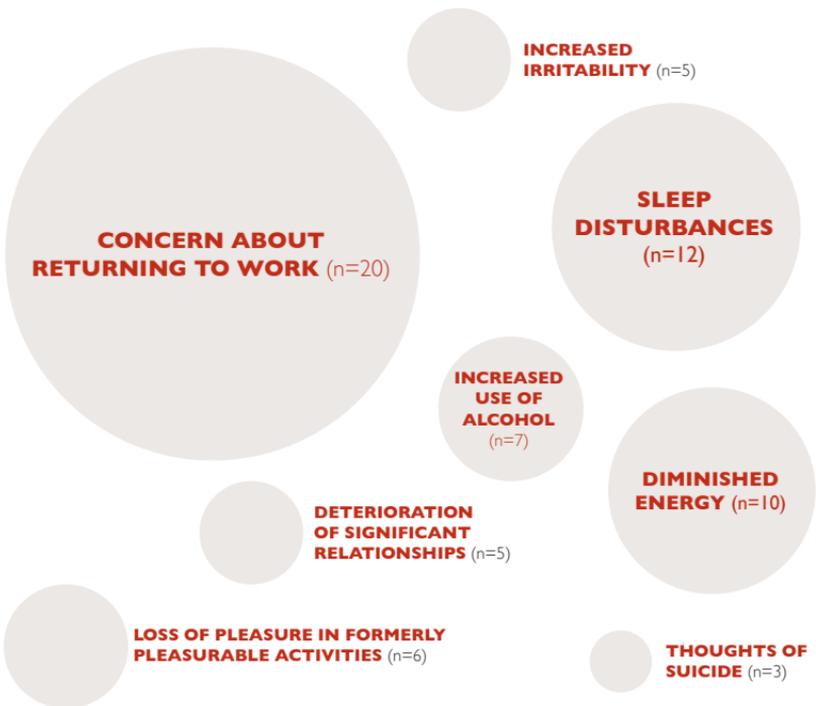
... the thing men do [is to] be brave.

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When interviewers asked seafarers how they handle emotional concerns, answers varied greatly. A significant minority of seafarers cited spiritual belief as helpful for coping with worries, turning to prayer or meditation for relief. Others suggested that fellow crewmates could function as sources of support under certain circumstances. Most seafarers expressed vague concerns about psychological complaints as described above; many felt the “thing men do” is to “be brave.”

NOTABLY, WHEN SEAFARERS WERE ASKED IF THEY FELT THEY RECEIVED ADEQUATE “MENTAL PREPARATION” FOR TRAVERSING KNOWN ZONES OF PIRACY, ALMOST ALL RESPONDENTS SAID THEY DID NOT.

In the subsample of 25 seafarers held captive (or who had close calls with pirates), most endorsed experiencing some clinically significant symptoms afterwards. These symptoms included the following:



WITHIN THIS GROUP, LESS THAN 1/3 FELT THEY HAD RECEIVED ADEQUATE FOLLOW-UP CARE.

Generally, seafarers from the Western hemisphere received more **post-event care** than those from the Eastern hemisphere. Of those who received any care, most seemed unclear as to what to expect from contact with a mental health specialist. Two of the seven who felt they received adequate care felt they benefited from it, as in the case of a captain of a pirated vessel who was “very surprised that just talking to someone over a few months restored [his] confidence to work.” Within this sample, rank, age, and years of experience showed no correlation to subjective descriptions of stress, suggesting that all seafarers are equally vulnerable to the effects of piracy. Further, length of captivity appeared directly related to the quantity and intensity of symptom complaints. Seafarers with a history of personal trauma that predated captivity experienced greater distress, emphasizing the importance of accounting for seafarers’ prior experience with trauma as a relevant factor in planning interventions.

WHEN ASKED WHAT BARRIERS INHIBITED THEIR CARE, MANY SEAFARERS CITED PRIVACY CONCERNS.

Concerns about the **disclosure of medical records** without permission connected directly to concerns of being “blacklisted” by the industry, especially when seafarers must renew work contracts frequently.

DISCUSSION

CLINICAL RESEARCHERS FOUND AN INCREASED STRESS LEVEL AMONG SEAFARERS AS COMPARED TO THREE YEARS AGO.

Even as the incidence of Somali piracy declines in 2012, the psychological impact on seafarers remains—and is likely to increase—as piracy continues and episodes of captivity become better known among the seafaring community. The industry, seafarer welfare organizations, and the international mental health community must collaborate in responding to current and anticipated seafarers' mental health needs.

Guardedness on the part of the seafarer for employment and cultural reasons complicates clinical assessment, as does the absence of available resources to conduct proper assessments. The prominence of post-traumatic stress disorder (**PTSD**) research may prove useful in orienting attention to potential post-piracy problems, but PTSD poses too restrictive a paradigm within which to operate. Competing explanations of PTSD complicate clinical intervention protocols, including significant differences between the American Psychiatric Association's diagnostic criteria in the DSM-IV-TR and the European standard in the ICD-10 (Peters, Slade, & Andrews, 1999). The implication suggests that if analysts assess seafarers only for PTSD, other clinically relevant symptoms such as major depression, acute bereavement, and psychotic disorders may go untreated (McHugh & Treisman, 2007). Further, emphasizing illness ignores resiliency factors in individual seafarers which, if bolstered, may improve recovery and possibly thwart development of later symptoms (Southwick, Vythilingam, & Charney, 2005). Even using an expanded, more general paradigm, the question still remains about which assessments evaluators should practically employ.

SCI'S CLINICAL RESEARCHERS ARE PREPARING A RECOMMENDED ASSESSMENT BATTERY.

Ideally, clinical researchers work collaboratively to publish an appropriate assessment battery in seafarers' native languages; make evaluations quick to administer; and create a battery administrable online.

Initial clinical assessment after captivity remains a major concern—with little consistency or agreement on best practice. Premature attempts at debriefing, including Critical Incident Stress Debriefing (**CISD**), may present problems (Foa E., 2009). Both seafarers' accounts and clinical wisdom indicate that after receiving complete physical examinations by medical doctors or nurses, seafarers must have material needs addressed, such as new clothes, haircuts, shaving and showers. In the first days after release, this appears sufficient. A proper medical examination can record preliminary observations of a seafarer's mental state. Observers should translate reports into the seafarer's native language, subsequently sending them to those responsible for care upon repatriation.

Once home, professionals should conduct proper **psychological assessments** at baseline and then at 3-6 month intervals in the first year (with shorter intervals for those identified as high risk) to monitor for the emergence of symptoms. Caregivers should initiate treatment only when symptoms are present and not as a general precaution (Foa, Keane, Friedman, & Cohen, 2009, p. 129). Where symptoms or major risk factors for future psychopathology exist, treatment should be provided according to local best standards, informed by the psychiatric and psychological literature. In places without appropriate medical professionals, the shipowner should provide competent personnel to conduct assessments and provide treatment. Examples of appropriate treatment can include supportive psychotherapy, cognitive behavioral therapy including exposure therapy, eye movement desensitization and reprocessing (EMDR), and the use of psychiatric medication (Bradley, Greene, Russ, Dutra, & Westen, 2005).

Strict **confidentiality agreements**—those that protect the patient-doctor relationship and only permit disclosures where the potential for self-harm or harm of others is likely—should constrain the actions of all personnel involved at any point in time and at any level of care. This confidentiality should include concerns about a seafarer returning to work. Until legal privacy safeguards are in place, responsible parties must give priority to protecting seafarers' health over their financial concerns. But one need not follow from the other: Proper rehabilitation yields a seafarer capable of serving effectively and safely, and ship owners should remember

that a seafarer who discloses symptoms and receives treatment is a safer employee than one who keeps silent for fear of lost income. Similarly, developing industry-wide protocols for resiliency training (preparation designed to minimize the likelihood of traumatic consequences due to contact with piracy) could lower risks of psychological consequences and resulting disruptions in the labor force.

Although not the focus of this study, piracy also affects the **wellbeing of seafarers' families**. Attending to captives' immediate relatives' economic and social needs remains an essential component in caring for the seafarer. Families must continue to receive income owed to the seafarer to help produce a sense of stability through the difficult time of captivity and must be provided access to mental health specialists to improve coping. Because social support becomes an integral part of a seafarer's recovery, family members need help to deal with the burden of assisting in that recovery.

STIGMAS ASSOCIATED WITH MENTAL HEALTH SYMPTOMS AND TREATMENT REMAIN ONGOING CONCERNS.

At the individual level, seafarers may consider disclosure of emotional suffering a sign of weakness and shame. This bias inhibits disclosure, limiting access to care. As a culture, the expectation that self-reliant seafarers are hardy and resilient adds group pressure to the individual level. Additionally, seafarers' ethnic and national cultures may hold biases that obstruct access to effective treatment. Shipowners must redouble and sustain current efforts to educate seafarers about symptoms of concern as well as providing means to receive care at sea and at port. Developing company and insurance protocols to intervene before the severity of symptoms increases helps ensure disclosures of mental health issues. Maritime stakeholders have moral and ethical obligations to promote an environment where disclosures about mental and physical health concerns facilitate diagnosis, treatment, and rehabilitation rather than dismissal from employment.

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This research represents an initial foray into seafarers' mental life. Future publications will continue to describe the data collected so far as well as ongoing conversations with seafarers. Continuing to develop paradigms for resilience training of seafarers and for ensuring the engagement of reliable, quality care mechanisms remains a priority. International partnerships and collaboration among clinicians and seafarer welfare organizations should benefit seafarer wellbeing, and cooperation among organizations like SCI, the Maritime Piracy Humanitarian Response Program, and Oceans Beyond Piracy point in this direction and represent an important beginning to ensure thorough, comprehensive care for seafarers affected by piracy anywhere in the world.

Corresponding Author

MICHAEL STUART GARFINKLE, PHD

Clinical Researcher

The Seamen's Church Institute

817 Broadway

Ninth Floor

New York, NY 10003-4709

michael.garfinkle@mssm.edu

+1 917-209-7747

Published September 2012



THE SEAMEN'S CHURCH INSTITUTE

74 Trinity Place, Suite 1414

New York, NY 10006

+1 212-349-9090

SEAMENSCHURCH.ORG